



AUG 28 2000

Dear Tribal Leader:

This letter and its enclosure provide my interim decisions for distributing the fiscal year (FY) 2000 Indian Health Care Improvement Fund (IHCIF). I assure you that there will be an annual computation of IHCIF distribution with consultation.

The Congress has requested a measurable description of the health care needs of American Indians and Alaska Natives AN/AI and the costs of providing needed health services. A starting point for such a description is to recognize a standard of health services for Indian people that is at least comparable to that most enjoyed by insured Americans.

I convened the Level of Need Funded (LNF) Workgroup to guide a scientific study to produce the required information. The Workgroup was charged to consider actuarial approaches for defining needed health benefits and forecasting costs. Contemporary actuarial methods have become extremely sophisticated and have the important advantage of being widely recognized in the health care industry and by Federal and State Government officials and legislators. Since beginning work in November 1998, the LNF Workgroup has produced two reports.

The LNF Workgroup Report, "Part 1: Level of Need Funded Cost Model" describes an actuarial model that measures a health care funding gap for Indian people compared to insured Americans. The study found IHS funding was only 60 percent of the actuarial cost for a mainstream benefits package not including "wrap-around" services such as sanitation and public health. I distributed the Part 1 report and invited comment in an August 3, 1999, letter to over 700 tribes and Indian health leaders. Most comments supported the actuarial approach to better measure unmet health-funding needs of Indian people.

The LNF Workgroup Report, "Part 2: Actuarial Cost Model for Local Operating Units and a Proposed Resource Allocation Strategy," measures health-funding variations within the Indian health system and identifies a methodology for distributing IHCIF appropriations based on equity principles. The local level

analysis identified funding variations from 30 percent to 100 percent of the need forecast in the actuarial model. The Workgroup recommended a formula to distribute IHCIF funds to units that are funded at less than the IHS average (60 percent). The Workgroup did not recommend reducing existing IHS funding for any unit, but to apply the IHCIF formula to close the funding gaps within the Indian health system. I distributed the Part 2 report and invited comment in a December 27, 1999, letter to tribes and Indian health leaders. Since then, comments supporting and opposing various details of the proposed distribution formula were received.

I asked the LNF Workgroup to review the comments and to consider revisions to the distribution methodology considering perspectives from Indian country. The Workgroup made a number of revisions to the methodology and sent recommendations to me in June 2000. The Workgroup did not replace direct consultation, but provided a vehicle for articulating the aggregate views provided from Indian country. I have considered the Workgroup recommendations and additional views provided by tribal leadership.

#### **Non-Recurring Distribution While Consultation is Continued**

The Congress appropriated \$10 million in FY 2000 for an IHCIF. After 18 months of study, two tribal leader mailings, many public presentations, and more than 6 months for comment, it is clear that additional refinement and tribal consultation is necessary. Views among stakeholders are not sufficiently settled to justify final determination on a matter that could set a precedent for many years. However, funds appropriated for FY 2000 must be distributed during this fiscal year, which ends September 30, 2000. Moreover, the Congress remains very interested in allocating the \$10 million IHCIF using "equity" principles.

Therefore, I have decided to distribute the \$10 million IHCIF on an interim basis while continuing consultation to finalize a permanent methodology to apply in FY 2001 and afterwards. The FY 2000 IHCIF distribution will be non-recurring. Distribution of the \$10 million, plus any additional IHCIF funds the Congress may appropriate for FY 2001, will be distributed on a recurring basis in FY 2001 following finalization of an IHCIF methodology, and full tribal consultation on that methodology.

#### **Interim Distribution Formula with Two Parts**

The Indian Health Care Improvement Act, Public Law (P.L.) 94-437, Section 102, specifies distribution criteria for the IHCIF based on "health status and resource deficiency" taking into account "cost of providing health care services given local geographic,

climatic, rural, and other considerations." The distribution methodology recommended by the LNF Workgroup does consider these factors.

I have considered other formulas for interim use including the Catastrophic Health Emergency Fund (CHEF) and Tribal Size Adjustment (TSA) formulas. While appropriate for other purposes, these formulas are based on methodologies that do not comply with specific IHCIF requirements contained in P.L. 94-437.

After traveling extensively in all 12 IHS areas and listening carefully to many views on this issue, I have decided to distribute the \$10 million IHCIF using an interim 2-part approach applicable only to FY 2000. \$9 million is distributed using the formula recommended by the LNF workgroup, and \$1 million is distributed using the Contract Health Services (CHS) formula. A description of the revised IHCIF methodology is enclosed at Tab A. A series of charts illustrating local and regional variations that are considered in the methodology is enclosed at Tab B.

I believe the IHCIF methodology, which is based on sophisticated actuarial data, can be further improved. I have seen first hand the wide-ranging diversity of circumstances and needs in Indian country. I understand how difficult it is to fully represent that diversity in a single national methodology. For instance, in every area I visit, I regularly hear about the severe and growing shortages of CHS funds to pay for costs of purchased medical care and pharmaceuticals. I have identified \$1 million for distribution with the CHS formula, not because this tiny amount can possibly relieve the financial stress, but as a sign to Indian health leaders that I hear and take your concerns seriously. In the coming months the IHS will continue consultation to improve the interim approach before I approve a permanent methodology.

#### **FY 2000 IHCIF Distribution**

The FY 2000 IHCIF distribution is enclosed at Tab C. Funds are identified for local units within IHS Areas.

Not all units identified at Tab C are self-contained units. In some locations, the Indian health care system is composed of multiple parts that may overlap. For instance, Indian patients in some locations obtain ambulatory services at a tribally operated clinic while inpatient services are provided elsewhere, sometimes from an IHS-operated hospital. It is difficult to represent these complexities in a methodology covering the entire Indian health system. Therefore, the Area office, with consultation, may distribute IHCIF funds received for such units among the constituent parts based on actual usage patterns or similar equitable measures.

**Additional Work and Consultation**

I have asked the LNF Workgroup to continue refining a methodology for the IHCIF that considers the feedback from tribes and Indian health leaders. I have asked the Workgroup to improve measures of health care prices that vary in Indian country especially relating to CHS, consider additional data on the severe disparities in Indian health status, and improve data on other health care resources available to Indian people. I also have asked my senior staff to organize additional consultation with tribes and Indian health leaders in the coming months.

I hope we can all continue our work together to address the troubling and enormous disparities in the health funding and health status of the Indian people we serve.

Sincerely Yours,

/Michael H. Trujillo/

Michael H. Trujillo, M.D., M.P.H., M.S.

Assistant Surgeon General

Director

Enclosure